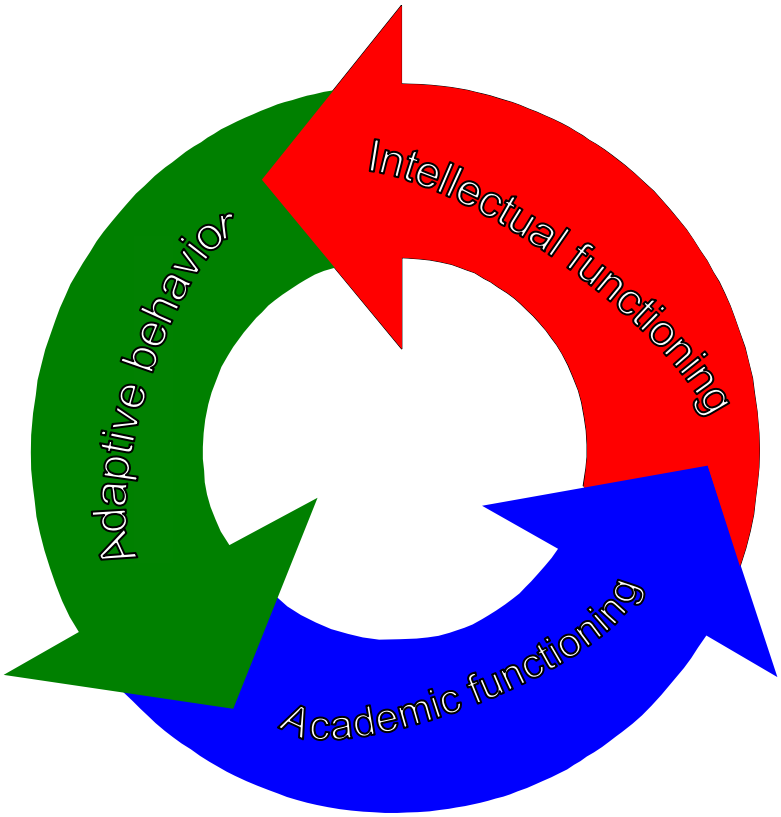
COGNITIVE DISABILITY EVALUATION AND DECISION-MAKING



Evaluation Guide

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INTRODUCTION

Development of the Technical Assistance Documents

With the passage of the new rules, Ch. PI 11.35, Wis. Stats., relating to need for special education and Ch. PI 11.36, Wis. Stats., relating to new eligibility criteria for six of the impairment areas contained in Sub.V Ch. 115, Wis Stats., it is imperative that all who are involved in evaluating children have a clear understanding of the requirements. The Department of Public Instruction (DPI) has developed these technical assistance documents to assist the reader in understanding each of the new provisions of the rules and to give guidance in evaluating children to determine if they have an impairment and a need for special education. The six documents relate to: cognitive disabilities (CD), visual impairments (VI), hearing impairments (HI), speech and language impairments (S/L), specific learning disabilities (SLD) and emotional behavioral disabilities (EBD). The overall purpose of these documents is to serve as a resource for Individualized Education Program (IEP) teams and designed to address four primary objectives:

(1) To clarify changes in the new rules regarding need for special education and eligibility criteria.

(2) To operationalize the eligibility criteria for each of the impairment areas that have changed.

(3) To highlight assessment practices that assist the IEP team when evaluating a child.

(4) To provide clarification of the process the IEP team must use to determine if the child needs special education and related services.

There have been concerns in Wisconsin and nationally of increasing identification rates. During the spring and summer of 2001, specific disability task forces met to provide input for the content of the documents. These technical assistance documents are the end result. We recognize the critical importance of appropriate identification. Each child should be labeled only if necessary for educational services.

I. HISTORICAL PERSPECTIVE

Changing Paradigms in Service Delivery Systems

The field of cognitive disabilities has undergone dramatic changes in the 20th century. These changes have been characterized as a shift in paradigms, with resultant changes in societal responses to persons with disabilities. A fundamental outcome of these shifts is the manner in which service delivery systems are organized and implemented. Paradigms for the provision of services for individuals with cognitive disabilities have been described as facility-based, services-based, and supports-based (Polloway, Smith, Patton, & Smith, 1996). The following section provides a brief discussion of these paradigms and their implications for professional practices.

Programs for persons with developmental disabilities during the early to middle 1900's were based on a facility-based paradigm. The underlying assumption behind this paradigm was that individuals' needs could best be met if they were grouped with others who were similarly diagnosed. The outcome of this approach was the development of institutions such as state schools and residential centers. Although this period had strong advocates for deinstitutionalization, there was considerable concern that community-based programs would be inadequate for persons with special needs.

Throughout this period, there were considerable changes in the way in which cognitive disabilities was defined and assessed. Prior to the early 1900s, definitions of cognitive disabilities emphasized social competence, social norms, and adaptability to the environment (Harrison & Robinson, 1995). The development of the intelligence quotient (IQ) test by Binet and Simon in 1905 propelled the movement of using psychometric measures to define mental retardation and a deemphasis on adaptive skills and social competence. However, by the mid-1900s, professionals in the field called for a return to adaptive behaviors as a critical component in the diagnosis of cognitive disabilities. This concern was reflected in the American Association of Mental Deficiency (AAMD) classification of cognitive disabilities, which stipulated the presence of deficits in adaptive behavior as a criterion (Heber, 1961).

During the middle of the century, the emergence of a services-based paradigm drew attention to the inequalities evident in facility-based programs. This change was driven by public exposure to the poor quality of many custodial institutions, as well as a philosophical change in desirable outcomes for persons with cognitive disabilities. A primary assumption behind this shift was that appropriate programming for individuals with developmental disabilities would prepare them for successful integration into community settings (Polloway, et al., 1996). During the early 1970s, implementation of services-based programs led to the now familiar special education classrooms, sheltered employment workshops, and community residential centers.

Throughout this period, IQ test scores continued to be used as the primary criterion in special education decision-making about cognitive disabilities (Reschly & Ward, 1991). This period also saw the advent of litigation with respect to the use of IQ scores and the overrepresentation of minority children in special education classes (Larry P. v. Riles, 1972; Marshall v. Georgia, 1984). In many cases, this litigation caused a serious re-evaluation of using IQ tests as the primary indicator of cognitive disabilities. Concurrently, the importance of adaptive behavior in defining cognitive disabilities was reestablished. As a result, the Education for all Handicapped Children Act (1975) adopted the AAMD definition of cognitive disabilities which included the identification of deficits in adaptive behavior as well as below average intelligence (Heber, 1961).

The last decade has seen a gradual movement toward a supports-based paradigm. This shift has been described as a move away from a deficit (within the person) orientation towards an outcome-based orientation that emphasizes the social and community roles of persons with cognitive disabilities (Greenspan, 1995). Fundamental assertions behind this model are that individuals should be maintained and supported in inclusive settings as appropriate to ensure successful learning, work experiences, and adjustment to the demands of community living. With respect to schools, a support-based paradigm is congruent with the position that special education is a **set of services** brought to natural environments rather than a **set of places** where services are provided.

Why Change the Definition and Eligibility Criteria for Cognitive Disabilities?

In November of 1996, the department held twelve informational hearings throughout the state relating to special education requirements under Ch. PI 11, Wisconsin Administrative Code. At these hearings, there was much support to update the definition of cognitive disabilities (CD) and to modify the eligibility criteria. As a result of testimony presented at those hearings, the state superintendent appointed a task force to develop criteria to modify the eligibility criteria for CD and to develop criteria to assist IEP teams in determining the need for special education.

The definition is adapted from the 1992 American Association of Mental Retardation (AAMR) definition. This is the current definition used in many states as well as in the developmental disability field. This definition replaces the AAMR definition of 1973 that we have been using. This definition takes into account the paradigm shift explained in the first section and assists the IEP team in identifying needs and strengths of the child in order to describe the services needed rather than the place where services are provided.

The eligibility criteria remove the artificial separation by intellectual level and consider the child as a whole. Rather than further labeling the child as having a CD-mild/moderate/severe/ profound impairment under the intellectual area, the criteria indicates that the child has a cognitive disability. The needs of the child are then discussed in the context of program planning rather than IQ. The IEP team, when determining placement, will then look at the service needs of the child rather than placing a child by intellectual functioning.

The eligibility criteria strengthen the need to assess the individual adaptive behavior areas and assist the IEP team in program planning for the child rather than obtaining one overall adaptive behavior score. There are a number of reasons explained in AAMR (1992) why obtaining one overall adaptive behavior score would not be productive. First, there is often within subject variation in adaptive behavior, it is critical to report component scores in order for the assessment process to have meaning. Second, many facets of a child's behavior are sampled in adaptive behavior assessment, the reliance on a single score would result in the omission of a description of these behaviors in a daily life context. Third, a profile of scores and or skill descriptions of these behaviors has significance to assist in program planning for the child.

The eligibility criteria concentrates on standard scores in academic areas rather than on grade level measurements. It is important to address the child's academic performance in relation to same age peers. Discrepancies between the child's performance and expectations in the educational environment must be identified in core academic areas in comparison to same-age peers in the general education program.

II. Individualized Education Program (IEP) Team Process–Evaluation

Evaluation is an essential part of the special education process for children with disabilities. Children are evaluated initially to see whether or not they have an impairment and whether, because of that impairment they need special education and related services. Information gathered during the evaluation helps to determine the educational needs of the child and to guide the IEP team in determining the services that are appropriate for the child. Federal and state special education law is specific about requirements for evaluating students. This section will briefly highlight those provisions of the law. Further details can be found in s. 115.782, Wis.. Stats., and in federal Individuals with Disabilities Education Act (IDEA) of 1997 regulations 34 CFR 300.530-536.

Referral

- Any person who reasonably believes that a child is a child with a disability may refer the child to a local education agency.
- Certain individuals such as physicians, nurses, psychologists, social workers, administrators of social agencies, and school personnel are required to make a referral when they suspect a child has a disability.
- All referrals must be in writing.
- Prior to submitting the referral a person required to make a referral must inform the child's parent.
- When the LEA receives the referral, the 90 day timeline from receipt of referral to sending placement notice begins.
- School districts must have written procedures describing the referral process.

The IEP Team

When a child is referred, the LEA appoints an IEP team (s. 115.777, Wis. Stats.). This IEP team includes:

- **The parents of the child**. Parents are equal participants on the IEP team throughout the process.
- **At least one regular education teacher** if the child is or may be participating in a regular education environment. It is the intent of the law that the regular educator should be one who is or will be teaching the child.
- **At least one special education teacher** who has extensive and recent training and experience related to the child's known or suspected disability or, where appropriate, at least one special education provider of the child.
- **A Local Education Agency (LEA) representative** who is qualified to *provide, or supervise* the provision of special education, is *knowledgeable about the general curriculum* and is *knowledgeable about the availability of and authorized to commit LEA resources*. This individual can also fill another role if the individual meets the requirements for another role.
- **An individual who can interpret the instructional implications of evaluation results.** This individual can also fill another role.
- **Other individuals at the discretion of the parent or LEA**, including related services personnel as appropriate. It is important to be aware that the occupational therapy, physical therapy, and school nursing practice acts and professional standards require an evaluation prior to providing services. A representative from birth to three programs or Head Start should be included when referring preschool children.

- **The child, whenever appropriate.** The student must be invited to any IEP meeting where transition is discussed.

IEP Team Duties

- The IEP team is responsible for three basic activities:
  - First, to **evaluate** the child to determine whether the child has or continues to have a disability and to identify the child's educational needs.
  - Second, for each child who has a disability, **to develop, review, and revise** the child's IEP.
  - Third, **to determine** a special education placement for each child who has a disability.
- It is important to remember that these activities are part of a unified and fluid process. The IEP team can complete these activities in one meeting or more than one. Evaluation information is used to identify appropriate goals and objectives for the student to work on throughout the year. The basic idea is that those who know and care about the child collaborate to identify and meet the child's needs.

Evaluation Activities

- The IEP team completes three basic activities during any evaluation. These activities are common to both initial and re-evaluations although there are some procedural differences between the two.
- First, the IEP team **reviews existing data** and determines whether additional data are needed. A review of existing data is always the first step of any evaluation.
- If additional data are needed, the IEP team **conducts any necessary tests and other evaluation materials** in order to determine if the child is or continues to be a child with a disability.
  - The LEA assesses the child in all areas of suspected disability and conducts a non-discriminatory evaluation. (The provisions for a non-discriminatory evaluation are found at s. 115.782(2)), Wis. Stats.
  - Each participant who administers new tests or evaluation materials completes an individual summary of findings.
- The IEP team then **completes an evaluation report.**

Initial Evaluation

- Following the receipt of an initial referral, the LEA provides the parent with a notice that a referral has been made.
- The notice includes the individuals the LEA has appointed as IEP team participants in addition to the parent and student as appropriate, and the qualifications of those participants.
- The IEP team reviews existing data and determines whether additional data must be collected in order to determine whether the child is a child with a disability and to identify the child's educational needs.
- The IEP team must review existing data **including information provided by the parents**, previous interventions and their effects, current classroom-based assessments and observations by teachers and others. After doing so, the IEP team decides whether additional data is needed. Existing data would include any information from outside sources including evaluation data for a child transitioning from a Birth-three or Head Start program.

- It is not required to have an IEP team meeting to review existing data, however, the IEP team may decide to this in a meeting.
- If the IEP team, which includes the parents, finds that ***no*** **additional data is needed, the LEA notifies the parents in writing of the finding and reasons for it.**
- The next step is to invite the parents to an IEP team meeting and make a determination about whether the child has a disability based on existing data.
- If there is a disagreement between the parent and the LEA that cannot be resolved about whether additional data are needed, the parent or LEA may pursue mediation, due process and/or complaints (as at all stages of the IEP process).
- If the IEP team, which includes the parent, **determines additional information is needed**, the IEP team specifies what data are needed and the qualifications of evaluators who will collect the data.
- Parents are notified of this decision in writing. The notification includes all evaluation procedures, tests, or other evaluation materials that will be used, who will be conducting the assessment (if known) and their qualifications.
- **Parental consent** is needed before administering new tests or other evaluation materials. Parents may revoke their consent at any time prior to the completion of the evaluation.
- Following the administration of tests and other evaluation materials, the IEP team meets, reviews all evaluation information, and makes a determination as to whether the child is a child with a disability.

Re-evaluation – General Provisions

- Re-evaluations are conducted at the request of the child's parent or teacher, when conditions warrant, and at least once every three years.
- The procedures for re-evaluation are essentially the same as for initial evaluations.
- Prior to beginning a re-evaluation, the LEA provides the parents with **written notice**. This notice informs the parents that the LEA intends to reevaluate the child and the reason for the re-evaluation.
- The notice also includes the IEP team participants, in addition to the parent and child (if appropriate), who have been appointed by the LEA, their names and qualifications.
- **The IEP team reviews existing data including:**
  - Existing evaluation data.
  - Information provided by the parents.
  - Previous interventions and their effects.
  - Current classroom-based information.
  - Observations and interviews.
- Upon re-evaluation, if after reviewing existing data, the IEP team determines **no additional data is needed**, the LEA **notifies** the parent in writing of the finding and the reason for it, and the parent's right to request assessment to determine whether the child continues to be a child with a disability (please note that the parent is an IEP team participant and thus knows that this decision has been made. Providing them with written notice is a statutory requirement).
- If **additional data is needed**, the parent is **notified**, and a description of the types of tests and other evaluation materials to be conducted and names (if known) and qualifications of examiners are provided.
- **Parental consent** is needed before administering new tests, assessments, or other evaluation materials.

- **Except,** consent need not be obtained if LEA has taken reasonable measures and parents fail to respond. This is different than if the parent refuses to give consent.

Evaluation IEP Team Determination

- Based on the review of existing data (and the results of new tests and other evaluation materials if administered), the IEP team determines:
  - whether the child has or continues to have impairment listed in s.115.76 (a), Wis. Stats.,
  - the present levels of performance and educational needs,
  - whether the child needs special education; and
  - whether additions or modifications to the special education and related services are needed to enable the child to meet the measurable, annual goals specified on the child's IEP and to participate, as appropriate, in the general curriculum.
- This determination is an important bridge between evaluation and program planning and is documented as part of the IEP development and review process.
- The IEP team may not determine that a child is a child with a disability solely because the child has received insufficient instruction in reading or math or because the child has limited proficiency in English.

Evaluation Participant Summary of Findings

- Each IEP team participant who conducts new tests, assessments, or other evaluation materials submits a summary of their findings.
- This summary is made available to all IEP team participants at the IEP team meeting when the data is discussed. It is also attached to the evaluation report.
- The summary of findings is:
  - in writing,
  - about one page in length,
  - understandable to all IEP team participants, and
  - includes information about the child's strengths and needs that will be useful to program planning.
- It is not intended to be a lengthy report nor just a list of standardized test scores.
- Each Summary of Findings becomes part of the Evaluation Report and is not a "stand alone" document.
- Please note: It is not appropriate for an IEP team participant to make recommendations about whether a child meets eligibility criteria on their individual summary of findings. This decision rests with the IEP team as a group.

Evaluation Report

- The IEP team documents the evaluation findings in its evaluation report. This includes information from:
  - review of existing data*;*
  - findings from any new or additional tests or evaluation materials administered including participants' summaries of findings, and

- determination of eligibility for special education including:
    - whether the child has an impairment,
    - if the child needs special education,
    - additional required documentation if the child was evaluated for a learning disability. In addition, for a child suspected of having a specific learning disability (SLD), each IEP team member must certify in writing whether the report reflects his or her conclusion. If it does not, the IEP team member must submit a separate statement presenting his or her conclusions; and
    - additional required documentation if the child was evaluated for a visual impairment (VI) or if a child with a VI requires braille.

- The LEA informs all IEP team participants that they may request a copy of the evaluation report or additional time before the IEP team develops an IEP for the child.
- The LEA asks each IEP team participant if they would like a copy of the report or additional time prior to moving forward to develop the IEP.
- Any IEP team participant may request a copy of the evaluation report at any time, following the evaluation.
- Unless provided earlier at an IEP team, participant's request, a copy of the evaluation report is provided to parents with the placement notice.
- If the IEP team determines the child is **not** a child with a disability, it identifies any educational needs of the child and any LEA or non-LEA services that may benefit the child.
- Unless provided earlier, a copy of the evaluation report is provided with notice of IEP team findings that the child does not have a disability.

III. EVALUATION AND DECISION-MAKING

Cognitive Disabilities

Evaluation Practices

Throughout the identification process, IEP teams should be guided by specific evaluation questions relevant to instructional planning which provide information needed to make decisions concerning how best to meet an individual's needs. As IEP teams answer evaluation questions and gather evaluation data throughout the identification process, best practices in evaluation should be considered and implemented. The following minimal standards are provided to guide the selection of evaluation tools and decision-making throughout the evaluation process:

1. The purpose for evaluation needs to be clearly articulated and understood by all individuals involved.
2. Evaluation is a solution-focused process with the purpose of searching for answers to well-defined questions and not solely determining a condition or classification.
3. The limitations of evaluation tools and procedures and the tentative nature of conclusions based on data from these tools and procedures, need to be clearly stated and understood by all individuals in the evaluation and decision-making process.
4. Evaluation tools and procedures must meet generally accepted standards of technical adequacy of reliability and validity for decision-making about individuals.
5. Evaluation tools and procedures need to be culturally, racially, and linguistically unbiased.
6. Evaluation needs to be multifaceted and include:
   - ─multiple data sources (e.g., teachers, parents, students, and other service providers familiar with the student).
   - ─multiple types of data (e.g., qualitative and quantitative).
   - ─multiple types of tools and procedures (e.g., standardized measures and alternative methods of assessment).
   - ─multiple environments (e.g., classrooms, home, work, and community settings).
7. Evaluation needs to consider performance across time, not just data from a single point in time. Evaluation should be viewed as an information-gathering process that occurs across time rather than an isolated, time-bound event.
8. The evaluation process involves the systematic collection of meaningful, relevant information about an individual's performance.
9. The evaluation process must provide prescriptive information and include documentation of an individual's strengths as well as weaknesses.
10. It is critical to evaluate the individual's performance within the context of his, or her, current environment.
11. Significantly subaverage intellectual functioning is descriptive of an individual's behavior across many different settings and situations. The evaluation of intellectual functioning may include a variety of information sources including at least one individually administered intelligence test.
12. In addition to standardized measures, alternative methods for acquiring information on the individual's performance in academic functioning may be incorporated into the evaluation process depending on the level of the child.
13. The evaluation of adaptive behavior may include direct measures (e.g., informal and structured observations), as well as indirect measures (e.g., third-party interviews and rating scales), to evaluate the individual's performance in comparison to same-age peers from similar cultural backgrounds.
14. Decision-making about an individual is based upon the professional judgment of the IEP team with consideration of both quantitative and qualitative data about an individual's performance.

There are a number of factors to be considered regarding the collection of data during the evaluation process:

- First, the type of data collected must match the purpose of evaluation.
- Second, practitioners must collect a sufficient amount of data to answer questions in a reasonable, responsible manner.
- Third, the quality of the data must be considered. In this respect, the data collected during evaluation must enable practitioners to make valid decisions.
- Finally, the results of the evaluation process must provide guidance for professional judgment.

Another dimension of evaluation is the determination of what constitutes a significant deficit in a given area. The criteria for deficits will vary depending on the evaluation methodology and the specific question that is being addressed. Different evaluation methods use different units of measurement, thus, the standard for a significant deficit may vary across procedures. A broad categorization of these methods is as follows:

- **Review** of records refers to the process of collecting and evaluating existing information that is relevant to evaluation questions. This information may include grades, attendance records, classroom assignments, previous evaluation results, previous intervention outcomes, and medical records.
- **Interview** refers to the process of direct communication with the student, family members, and professionals to collect information regarding individual behavior across situations and settings.
- **Observation** refers to the process of systematically collecting information about adaptive behaviors across situations and settings by watching and recording events. Observations can focus on both individual performance and the environmental variables that surround the adaptive behaviors.
- **Test and ratings** refers to standardized instruments used for obtaining a sample of behavior or individual academic performance. Tests may include standardized or nationally-normed measures. Ratings include checklists and standardized forms completed by the student, parent, and teacher.

Multicultural Issues

The overrepresentation of minorities in special education is well documented, and overrepresentation of African-American children with cognitive disabilities continues to be problematic (Reschly and Ward, 1991). Of further concern is the continued inappropriate placement of children from minority backgrounds and children with limited English proficiency in special education. This problem is of special concern for minority children, especially for African-American males. Over-identification of minority children, particularly in urban schools with high proportions of minority students, remains a serious problem in this nation. The problem also contributes to the referral of minority special education students to more restrictive environments (Senate Committee Report on IDEA '97, 1997). In Wisconsin there is continuing concern that minority children are overrepresented in programs for children with cognitive disabilities.

Reschly and Ward examined the representation of African-American children in programs for mild cognitive disabilities and evaluated the extent to which adaptive behavior deficits were considered in eligibility and placement decisions. They found that African-American children were overrepresented in programs for children with mild cognitive disabilities nationally, classification was based primarily on IQ scores and neither white children nor African-American children were adequately evaluated in adaptive behavior.

As African-American children and children with linguistic diversity are being evaluated the IEP team must be sensitive to the issues of cultural and linguistic diversity. This requires the evaluator to rely on a multifactorial evaluation. When a child's background reflects cultural or linguistic variances, alternate approaches should be considered. Sociocultural background as well as the child's primary language should be considered in the selection and administration of evaluation tools and the interpretation of the results obtained from those evaluations.

IV. DETERMINING AND DOCUMENTING OF ELIGIBILITY

DEFINITION

Cognitive Disability means:

Significantly subaverage intellectual functioning that exists concurrently with deficits in adaptive behavior and that adversely affects educational performance.

- *Significantly subaverage intellectual functioning*... This is defined as an IQ standard score of approximately 70 to 75 or below, based on assessment that includes one or more individually administered general intelligence tests developed for the purpose of assessing intellectual functioning. These data should be reviewed by the IEP team and validated with additional test scores or evaluative information.
- *Existing concurrently with deficits in adaptive behavior*... The intellectual limitations occur at the same time as the deficits in adaptive behavior. The evidence of adaptive behavior deficits is necessary because intellectual functioning alone is insufficient for a child to have an impairment of cognitive disabilities. The impact on functioning of these deficits must be sufficiently comprehensive to encompass at least two adaptive behavior areas, thus showing a generalized deficit and reducing the probability of measurement error.
- *Adversely affects education performance…* The academic functioning deficits are found at the same rate as the limitations of adaptive behavior and intellectual functioning. All three areas must adversely affect the education performance of the child in comparison to same-age peers in the general education program.

The IEP team may identify a child as having a cognitive disability if the child meets the criteria specified in PI 11.36 (1) (b) with regard to:

A. Intellectual functioning,
B. Adaptive behavior, and
C. Academic functioning.

All three areas need to be met for the child to meet eligibility criteria for the impairment of cognitive disability.

INTELLECTUAL FUNCTIONING (PI 11.36(1)(b)

The first component of the eligibility criteria for CD is intellectual functioning. **To meet eligibility criteria under this component a child must have a standard score of two or more standard deviations below the mean on at least one individually administered intelligence test developed to assess intellectual functioning**. Evaluation data should be reported by IEP team participants experienced with children who have a cognitive disability and qualified in terms of professional and state regulations as well as publisher's guidelines to conduct a thorough, evaluation of the child's intellectual functioning. Assuming that appropriate standardized measures are available for the child's social, linguistic, and cultural background, and that proper adaptations may be made for any motor or sensory limitation, the intellectual functioning should be approximately two or more standard deviations below the mean. This criterion assumes a standard score of approximately 70 or below on scales with a mean of 100 and standard deviation of 15. (AAMR, 1992, pg. 35)

Individual intelligence tests yield a standard score that can be used as a working measure suggesting a range of intellectual functioning. As adapted from Grossman (1983, pg. 31) and

AAMR (1992, pg. 36), salient aspects of an intelligence quotient (IQ) (as derived from instruments with a standard deviations of 15) are summarized as follows:

1. An IQ of 100 is the mean, median, and mode of appropriately selected normative groups. Hence, a person receiving a standard score of 100 is considered to have an average level of cognitive functioning.
2. About one half of scores fall between 90 and 110. This is often said to indicate the range of "average" intelligence.
3. About two thirds of the scores are between one standard deviation below the mean of 100 and one standard deviation above the mean. Hence, assuming the standard deviation of 15 points common to many instruments, two thirds of IQs would be expected to lie between 85 and 115, one sixth below 85, and one sixth above 115. These percentages illustrate the concept of the normal distribution of intelligence.
4. About 2.3 percent of IQs would be expected to lie below 70 and a like percent above 130. Thus, hypothetically about 3 to 5 percent of the tested population may have significantly subaverage intellectual functioning.

The determination of subaverage intellectual functioning requires the use of measures that include different types of items and different factors of intelligence (Reschly, 1987). The instruments most commonly used for the assessment of intellectual functioning are the:

1. Stanford-Binet Intelligence Scale (Thorndike, Hagen, and Sattler, 1986),
2. Wechsler Scales (e.g., the Wechsler Intelligence Scale for Children-III [Wechsler, 1991; Wechsler Adult Intelligence Scale-Revised [Wechsler, 1981]; Wechsler Preschool and Primary Scale of Intelligence-Revises [Wechsler, 1989]),
3. Kaufman Assessment Battery for Children (K-ABC, Kaufman and Kaufman, 1983)

A child could meet eligibility criteria under this component, if the child has a standard score between one and two standard deviations below the mean on at least one individually administered intelligence test and the child:

- has been documented as having a cognitive disability in the past and,
- the child's condition is expected to last indefinitely.

This criterion will be used most often during a re-evaluation of a child with a cognitive disability. This means that an IEP team had to find the child met eligibility criteria for cognitive disability in the past. An example of this would be a student who was found to have a cognitive disability and a speech and language impairment at age 3. At age 6 the child was found to no longer have the impairment of cognitive disability and still had the impairment of speech and language. The student, now age 8 and in the third grade, is struggling and is reevaluated to determine if she meets eligibility criteria for speech and language and a cognitive disability. It was determined that she met eligibility criteria in the areas of adaptive behavior and academic functioning and had an IQ score of 78. If you apply the eligibility criteria of two standard deviations below the mean to this, the student would **not meet** eligibility criteria under intellectual functioning because the IQ score was higher than two standard deviations below the mean. By applying this part of the eligibility criteria she would **meet** eligibility criteria because the IQ score of 78 fell within the one standard deviation below the mean, she had been found to be a child with a cognitive disability in the past and the condition was expected to last indefinitely.

ADAPTIVE BEHAVIOR (PI 11.36)(1)(b)2

The second component of the eligibility criteria for cognitive disability is the existence of deficits in adaptive behavior. **To meet eligibility criteria under this component, a child has deficits**

in adaptive behavior as demonstrated by a standard score of two or more standard deviations below the mean on standardized or nationally-normed measures, measured by comprehensive individual assessments. These assessments include interviews of the parents, test, and observations of the child in adaptive behavior, which are relevant to the child's age. Deficits must occur in two or more applicable adaptive behavior areas;

- communication,
- self-care,
- home living,
- social skills,
- appropriate use of resources in the community,
- self-direction,
- health and safety,
- applying academic skills in life,
- leisure, and
- work.

In everyday use, adaptive behavior generally implies the achievement of skills needed for successful performance in typical environments (Bruininks, Thurlow, and Gilman, 1987). These skills are encompassed within two broad domains. The first is personal skill development, which includes the skills needed for self-care, home living, work, and recreation. The second is social competence, which involves the behaviors needed to interact appropriately with others in the community. Both of these areas encompass multiple skills that are expected at different age levels. The construct of adaptive behavior has been characterized as involving multiple elements (Harrison and Robinson, 1995) including (a) developmental changes, in that skills increase in number and complexity as individuals grow older; (b) multiple domains, including skill areas such as self-help, vocational, leisure and recreation (AAMR, 1992); (c) expectations and standards of other people in the individual's family, community, and culture; (d) demands of specific situations and environments, such as home, school, community and workplace; and (e) discrepancies between acquired skills and the functional performance of those skills in specific situations.

Adaptive behavior as a criterion for cognitive disabilities was adopted by the American Association on Mental Retardation-AAMR over 30 years ago. The concept of adaptive behavior was first formally included in the 1959 definition (Heber, 1959) and was defined in Grossman (1983) as follows:

> Adaptive behavior refers to the quality of everyday performance in coping with environmental demands. The quality of general adaptation is mediated by level of intelligence; thus, the two concepts overlap in meaning. It is evident, however, from consideration of the definition of adaptive behavior, with its stress on everyday coping that adaptive behavior refers to what people do to take care of themselves and to relate to others in daily living rather than the abstract potential implied by intelligence.

The current AAMR (1992) definition is accompanied by the assumption that adaptive behavior must be considered in the context of environments that are typical of the individual's age-peers, and in relation to the individual's needs and supports within the environments. It also asserts that limitations may coexist with strengths, and that an individual's functioning is likely to improve if appropriate supports and services are provided.

The following table provides a breakdown of AAMR (1992) adaptive behaviors for various ages.

Birth - 6 years	**6 - 13 years**	**14 - 21 years**
Communication	Communication	Communication
Self-care	Self-care	Self-care
Social skills	Social skills	Social skills
	Home living	Home living
	Appropriate use of resources in the Community	Appropriate use of resources in the Community
	Self-direction	Self-direction
	Health and safety	Health and safety
	Applying academic skills in life	Applying academic skills in life
	Leisure	Leisure
		Work

The authors of the AAMR definition (1992) have explained each of the ten adaptive areas in detail as follows;

1. *Communication:* Skills include the ability to comprehend and express information through symbolic behaviors (e.g., spoken word, written word/orthography, graphic symbols, sign language, manually coded English) or nonsymbolic behaviors (e.g., facial expression, body movement, touch, gesture). Specific examples include the ability to comprehend and/or receive a request, an emotion, a greeting, a comment, a protest, or rejection. Higher level skills of communication (e.g., writing a letter) would also relate to functional academics.

2. *Self-Car*e: Skills involved in toileting, eating, dressing, hygiene, and grooming.

3. *Home Livin*g: Skills related to functioning within a home, which include clothing care, housekeeping, property maintenance, food preparation and cooking, planning and budgeting for shopping, home safety, and daily scheduling. Related skills include orientation and behavior in the home and nearby neighborhood, communication of choices and needs, social interaction, and application of functional academics in the home.

4. *Social Skills:* Skills related to social exchanges with other individuals, including initiating, interacting, and terminating interaction with others, receiving and responding to pertinent situational cues, recognizing feelings, providing positive and negative feedback, regulating one's own behavior, being aware of peers and peer acceptance, gauging the amount and type of interaction with others, assisting others, making choices, sharing, understanding honesty and fairness, controlling impulses, conforming conduct to laws, violating rules and laws, and displaying appropriate sociosexual behavior.

5. *Appropriate Use of Resources in the Community (Community Use):* Skills related to the appropriate use of community resources, including traveling in the community; grocery and general shopping at stores and markets, purchasing or obtaining services from other community businesses (e.g., gas stations, repair shops, doctor and dentist's offices), attending church or synagogue, using public transportation and public facilities, such as schools, libraries, parks and recreational areas, streets and sidewalks; attending theaters, and visiting other cultural places and events. Related skills include behavior in the community, communication of choices and needs, social interaction, and the application of functional academics.

6. *Self-Direction:* Skills related to making choices, learning and following a schedule; initiating activities appropriate to the setting, conditions, schedule, and personal interests, completing necessary or required tasks, seeking assistance when needed, resolving problems

confronted in familiar and novel situations, and demonstrating appropriate assertiveness and self-advocacy skills.

7. *Health and Safety:* Skills related to maintenance of one's health in terms of eating, illness identification, treatment, and prevention, basic first aid, sexuality, physical fitness; basic safety considerations (e.g., following rules and laws, using seat belts, crossing streets, interacting with strangers, seeking assistance), regular physical and dental check-ups, and personal habits. Related skills include protecting oneself from criminal behavior, using appropriate behavior in the community, communicating choices and needs, participating in social interactions, and applying functional academics.

8. *Applying Academic Skills in Life (Functional Academics): Cognitive* abilities and skills related to learning at school that also have direct application in one's life (e.g., writing; reading; using basic practical math concepts; basic science as it relates to awareness of the physical environment and one's health and sexuality; geography; and social studies). It is important to note that the focus of this skill area is not on grade-level academic achievement but, rather, on the acquisition of academic skills that are functional in terms of independent living.

9. *Leisure:* The development of a variety of leisure and recreational interests (i.e., self-entertainment and interactions) that reflect personal preferences and choices and, if the activity will be conducted in public, age and cultural norms. Skills include choosing and self-initiating interests, using and enjoying home and community leisure and recreational activities alone and with others, playing socially with others, taking turns, terminating or refusing leisure or recreational activities, extending one's duration of participation, and expanding one's repertoire of interests, awareness, and skills. Related skills include behaving appropriately in the leisure and recreation setting, communicating choices and needs, participating in social interaction, applying functional academics, and exhibiting mobility skills.

10. *Work:* Skills related to holding a part or full-time job or jobs in the community in terms of specific job skills, appropriate social behavior, and related work skills (e.g., completing of tasks, awareness of schedules, ability to seek assistance, take criticism, and improve skills, money management, financial resources allocation, and the application of other functional academic skills; and skills related to going to and from work, preparation for work, management of oneself while at work, and interaction with co-workers).

A variety of adaptive behavior scales were developed in the wake of the formal inclusion of adaptive behavior in earlier AAMR definitions of mental retardation. As a consequence, there is relatively close correspondence between the structure of many of the scales and the implicit meanings within those definitions (Kamphaus, 1987).

For many years, the Vineland Social Maturity Scale (Doll, 1953) served as the standard measure of adaptive behavior. However, a variety of tools now are available and in common use. These instruments include the:

1. American Association of Mental Retardation Adaptive Behavior Scales and the School Edition of the ABS (Nihira, Leland, Lambert, 1993),
2. Vineland Adaptive Behavior Scales-Revised (Sparrow, Balla, and Cichetti, 1984),
3. Scales of Independent Behavior (Bruininks, Woodcock, Weatherman, and Hill, 1984),
4. Adaptive Behavior Rating Scale-School Version and home Version (McCarney, 1995)
5. Adaptive Behavior Assessment System (Harrison, Oakland, 2000).

Please refer to the appendix for an expanded list of assessment tools used in the adaptive behavior area.

Academic Functioning (PI 11.36(1)(b)

The third component of the eligibility criteria for CD is academic functioning. This component has been divided into two age ranges.

Ages 3 Years Through 5 (PI 11.36(i)(b)3a

To meet eligibility criteria under this component a child age three through five must have a standard score of two or more standard deviations below the mean on standardized or nationally-normed measures, as measured by comprehensive, individual assessments, in at least two of the following areas: academic readiness, comprehension of language or communication, or motor skills.

These can be defined as follows:

- Academic readiness includes cognitive activities such as the ability to acquire, use and retrieve information as demonstrated by the level of imitation, discrimination, representation, classification, sequencing, and problem-solving skills often observed in children's play. Evaluation tools may include:

    1. Battelle Developmental Inventory (BDI),
    2. Developmental Assessment of Young Children (DAYC),
    3. Learning Accomplishment Profile (LAP-D),
    4. Mullen Scales of Early Learning: AGS Edition.

- Comprehension of language or communication includes *expressive language*, such as the production of age appropriate content, form and use of language **and/or** receptive language such as listening, receiving and understanding language. Evaluation tools may include;

    1. Preschool language Scale-Revised (PLS-3),
    2. DAYC,
    3. BDI
    4. LAP-D.

- Motor Skills include gross motor skills, such as the ability to move around and interact with the environment with appropriate coordination, balance and strength; **or** fine motor skills, such as manually controlling and manipulating objects such as toys, drawing utensils, and other useful objects in the environment. Evaluation tools may include:

    1. Peabody Motor Development Scales,
    2. DAYC,
    3. BDI,
    4. LAP-D.

Ages 6 To 21 (PI 11.36(1)(b)3b

To meet eligibility criteria under this part of the component, the child age six to twenty-one has a standard score of two or more standard deviations below the mean on standardized or nationally-normed measures, as measured by comprehensive, individual assessments, in general information and least *two* of the following areas: written language, reading or mathematics.

General information is a critical component of achievement for children with cognitive disabilities; to meet eligibility criteria, a child must be two standard deviations below the mean on a standardized or nationally-normed measure in general information. Definitions of general information have been added to assist with understanding of the meaning.

General information has been defined as “a series of orally presented questions that tap the child’s knowledge about common events, objects, places, and people.” (page 6 WISC III Manual, The Psychological Corp., 1991).

It is further defined as “the breadth and depth of knowledge of a culture, the ability to communicate one’s knowledge, identifying where objects are found and what people typically do with an object and the ability to reason using previously learned knowledge or procedures, (page 11 Woodcock-Johnson III Training Presentation Fall 2000).

It also has been defined as “A combination of the sciences, social studies and humanities… and provides a broad measure of general information on achievement in these content areas.” (Woodcock Johnson).

The composite or overall general information/general knowledge score is used in determining a standard score of two or more standard deviations below the mean. The IEP team needs to look at scores that appear to be outside of this requirement and examine them with respect to the child's total testing profile. For those children who cannot be tested using standardized or nationally-normed measures, the general information score can be used from the general information section on an intelligence test that has been administered to the child.

Academic functioning also includes:

- Written language: The composite or overall written language score is used in determining a standard score of two or more standard deviations below the mean. The composite score may include assessments in the following areas: broad written language, basic writing skills, and written expression.

- Reading: The composite or overall reading score is used in determining a standard score of two or more standard deviations below the mean. The composite score may include assessments in the following areas: broad reading skills, basic reading skills, reading decoding (identifying printed words and letters), reading fluency (reading printed statements), reading comprehension (reading words and supplying appropriate meanings).

- Math: The composite or overall math score is used in determining a standard score of two or more standard deviations below the mean. The composite score may include assessments in the following areas: broad math skills, math calculations, math fluency, math applications, numerical operations, math reasoning.

A variety of assessment tools are used to assess academic functioning including:

1. Woodcock Johnson III, 2001,
2. PIAT –R, 1989,
3. Key Math–Revised, 1988,
4. Woodcock Reading Mastery, and
5. Woodcock-McGrew-Werden Mini Battery of Achievement, 1994.

For those children that cannot be tested using standardized or nationally-normed measures, the IEP team may use a variety of developmental checklists, observations, interviews, and other means to assess the child in the area of academic functioning.

Re-evauluation

A child with a cognitive disability must be re-evaluated at least once every three years, and more often if warranted. When re-evaluating, the IEP team must look at the program, interventions and supports that have been provided. Even though the child may not appear to meet initial eligibility criteria, the question to ask is, "What would happen if the team would decide to remove the program, interventions, and supports? The next question should be, "Does the child continue to need special education?" It may be that the child has made progress, but would not be able to handle the general education curriculum if the program, interventions, and supports were removed.

The focus during re-evaluation for the IEP team becomes making an informed decision as to whether the child continues to need special education.

NOTE:

At the end of eligibility criteria rules for CD, there are two notes added to help clarify the definition and assist IEP teams in determining if the child meets eligibility criteria. These are:

Cognitive disabilities typically manifest before age 18.

The current definition of CD used in the field continues to emphasize the developmental period as the time in which CD is initially manifested. The cutoff is set at age 18 to coincide with this philosophy and with the age of majority.

An etiology should be determined when possible, so that the IEP team can use this information for program planning.
According to Kozma and Stock (page 25, 1993) broad categories are used to categorize etiologies (known causes). These are as follows:

- Prenatal (occurring before birth)
  - A. Genetic
    1. Inherited Genetic Causes
    2. Noninherited Genetic Causes
  - B. Early alterations of embryonic development
    1. Specific syndromes
    2. Multiple congenital anomalies/mental retardation (multiple birth defects)
  - C. Other Prenatal (Acquired) Causes
    1. Alcohol/illicit substances/other drugs
    2. Maternal infections
    3. Other maternal health conditions
  - D. Pregnancy problems

- Perinatal (occurring around the time of birth)
  - A. Fetal oxygen deprivation (difficulties getting oxygen to the brain)
  - B. Prematurity

- Postnatal (occurring after birth)
  A. Infections
  B. Head Injuries
  C. Tumors
  D. Lead Poisoning
  E. Unknown factors

When the child is evaluated, if an etiology is known it may assist the IEP team in determining what supports and or resources may be needed to provide an appropriate program for the child.

SUMMARY

For a child three through five to meet eligibility criteria for cognitive disabilities for initial evaluation and re-evaluation:

1. He/she must be two standard deviations below the mean on at least one individually administered intelligence test or one to two standard deviations below the mean on at least one intelligence test if the IEP team has documented a cognitive disability in the past and the condition is expected to last indefinitely;
2. He/she must be two standard deviations below the mean in two of the three adaptive behaviors of communication, social skills or self-help skills; and
3. He/she must be two standard deviations below the mean in two of the three academic areas of academic readiness, comprehension of language or communication or motor skills.

For a child 6 to 21 to meet eligibility criteria for cognitive disabilities for initial evaluation and re-evaluation:

1. He/she must be two standard deviations below the mean on at least one individually administered intelligence test or one to two standard deviations below the mean on at least one intelligence test if the IEP team has documented a cognitive disability in the past and the condition is expected to last indefinitely;
2. He/she must be two standard deviations below the mean in two or more of the age relevant adaptive behaviors; and
3. He/she must be two standard deviations below the mean in academic functioning, in the area of general information and two of the three areas of written language, reading or mathematics.

V. Need for Special Education [PI 11.35(2)(3)]

PI 11.35 (2) A child shall be identified as having a disability if the IEP team has determined from an evaluation conducted under s. 115.782, Stats., that the child has an impairment under s. PI 11.36 that adversely affects the child's educational performance, and the child, as a result thereof, needs special education and related services.

PI 11.35 (3) As part of an evaluation or re-evaluation under s. 115.782, Stats., conducted by the IEP team in determining whether a child is or continues to be a child with a disability, the IEP team shall identify all of the following:

(a) The child's needs that cannot be met through the regular education program as structured at the time the evaluation was conducted.

(b) Modifications, if any, that can be made in the regular education program, such as adaptation of content, methodology or delivery of instruction to meet the child's needs identified under par. (a), that will allow the child to access the general education curriculum and meet the educational standards that apply to all children.

(c) Additions or modifications, if any, that the child needs which are not provided through the general education curriculum, including replacement content, expanded core curriculum or other supports.

A disability under federal and state special education legal requirements means the student meets the eligibility criteria for at least one of the impairments and has a need for special education. A student may meet the eligibility criteria for cognitive disability, but may not automatically need special education. Appendix - is a tool for guiding the IEP team's discussion about need for special education. The tool is not required, but may be useful in addressing the three issues related to need.

Throughout the determination of whether the student has an impairment, the IEP team also has been discussing the child's needs in relationship to program planning for the child. Once the IEP team has determined the impairment, the team participants now must decide whether the student needs special education and related services as the result of the impairment.

Need for special education is an important issue that often is overlooked - A child does not "automatically " need special education just because he meets the criteria for an impairment.

The IEP team should ask questions such as:

"Why does this impairment/why do these needs *require* special education? and
Does this really require special education and an IEP?"

If the IEP team determines that a child has an impairment and a need for special education, the child is considered a child with a disability. "Disability" means impairment **plus** need for special education. The new rules have included a process to assist the IEP team in determining if the student needs special education.

The rules state that:

As part of an evaluation or re-evaluation conducted by the IEP team in determining whether a child is or continues to be a child with a disability, the IEP team shall identify all of the following:

1. The child's needs that cannot be met through the regular education program as structured at the time the evaluation was conducted. When discussing this, the IEP team must remember that schools have an obligation to address through regular education some level of variability in the classroom. This first consideration requires the IEP team to scrutinize the regular education environment to identify needs that cannot be met in that environment as

structured. The IEP team must discuss the match/mismatch between the student's needs and the regular education program. If there is a match between regular education and the child's needs then the IEP team may decide that the child may have an impairment but does **not** need special education. If the mismatch is too great to meet the student's needs, the IEP team's analysis is not finished. An example of this may be a child who is unable to complete any assignments on her own and who needs assistance with self-help and dressing skills.

The IEP team must go on to the next level of analysis. The law states the IEP team must identify:

2. Modifications, if any, that can be made in the regular education program, such as *adaptation of content*, *methodology*, or *delivery of instruction* to meet the child's needs identified under par. (a) that will allow the child to *access the general education curriculum* and *meet the educational standards that apply to all* children.

It is not acceptable to take the position that the student must fit into the regular education program as currently structured. Schools have an obligation to adequately address a range of needs in all regular education programs. Flexibility, creativity and strong teaching skills should be factors of the analysis.

As the IEP team starts to discuss modifications that may be needed in regular education they should take into consideration the following:

- What is involved in implementing the modification? (Time to implement, time for training, preparation, short-term versus ongoing).
- Can the modification be used with other students as well?
- Is this modification based on the general education classroom curriculum?

Examples of adaptation of content include:

- large print or fewer items on worksheets,
- provide low readability texts,
- provide taped texts, and
- fewer items on worksheets.

Examples of adaptation of methodology include:

- changing how a concept is taught, such as teaching strategies needed to complete activities,
- using computer assisted software, and
- providing instruction in a variety of ways (visual, auditory, tactile).

Examples of delivery of instruction include:

- small group versus large group instruction and
- use of assistive technology.

Remember the IEP team is reviewing modifications that can be made in regular education to allow the student to access the general education curriculum and meet the educational standards that apply to all students. Changes that do not alter the expectations or general content of what is being taught are still considered the general education curriculum. If options can be provided relatively easily within the general education curriculum to address the child's needs and allow them to access the general curriculum and meet the standards that apply to all

children, the child is likely **not** to demonstrate a need for special education. If options cannot be provided relatively easily, these modifications may be provided as part of the special education services the child requires.

The last consideration the IEP team needs to address is modifications or additions, which are not provided through general education curriculum. The law states the IEP team must identify:

3. Additions or modifications, if any, that the child needs which are not provided through the general education curriculum, including *replacement content*, *expanded core curriculum*, or *other supports*.

Does the student have needs that cannot be met in regular education even after that environment is carefully scrutinized and appropriate modifications are considered? If so, as the IEP team considers the child's needs, the IEP team participants will need to identify any instruction and supports outside of the regular education curriculum that the student needs.

Examples of replacement content include:

- life-skills curriculum and
- functional academic curriculum.

Examples of expanded core curriculum include:

- a community -based work experience,
- social skills instruction, and
- self-determination/self-advocacy instruction.

Examples of other supports include:

- assistive technology,
- one-to-one instruction, and
- recreational activities, such as Special Olympics, Young Artists Workshop and Very Special Arts.

If the IEP team determines that a student meets eligibility criteria and has a need for special education, the student then has, or continues to have a disability. The next step for the IEP team will be to develop an IEP and placement for the student.

VI. APPENDICES

A. References

B. Evaluation Tools for Adaptive Behavior

C. Glossary of terms

D. Supports and Levels

F. Eligibility Worksheet

E. Tool for Determining Need for Special Education

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Evaluation Tools for Adaptive Behavior

Adaptive Behavior Assessment System (ABAS)
The Psychological Corporation
555 Academic Court
San Antonio Texas 78204-2498
1-800-872-1726
This tool assesses all ten areas, but addresses work at age 17.

Adaptive Behavior Rating Scale-Home Version (ABES-HV)
Adaptive Behavior Rating Scale-School Version (ABES-SV)
Hawthorne Educational Services, Inc.
800 Gray Oak Drive
Columbia MO 65201
1-800-542-1673
This tool assesses all ten areas.

AAMR Adaptive Behavior Scale-Residential and Community: 2 (ABS-RC:2)
AAMR Adaptive Behavior Scale-School: 2 (ABS-S:2)
Pro-Ed
8700 Shoal Creek Boulevard
Austin TX 78757
1-800-397-7633
This tool assesses all ten areas.

Scales of Independent Behavior (SIB)
Riverside Publishing Company
8420 Bryn Mawr Avenue
Chicago IL 60631
1-800-323-9540
This tool assesses eight of the ten areas.

Vineland Adaptive Behavior Scales-Classroom Edition (VABS-CE)
Vineland Adaptive Behavior Scales-Interview Edition-Expanded Form (VABS-IE(E))
American Guidance Service
4201 Woodland Road
P O Box 99
Circle Pine MN 55014
1-800-328-2560
This tool assesses three of the areas; communication, social and self-help. These are the three areas that must be addressed for children age three through five.

Adaptive Behavior Inventory (ABI)
Pro-Ed
8700 Shoal Creek Blvd
Austin TX 78757
1-800-397-7633
This is used as a screening tool and does not assess all ten areas.

Definition of Terms

A number of the terms used in this document are used differently across different individuals and contexts. The following section explains how they are used within this document. Definitions were taken directly from NASP (1994).

Interventions: Interventions are a type of specific supports designed to meet specific needs of children. Interventions can include activities to increase children's competence and skills. They can also include environmental or instructional modifications designed to facilitate the acquisition of such skills. A classroom placement alone (e.g., self-contained classroom) is not an intervention.

Problem Solving: Refers to a systematic process that includes the assessment of children and their environments, identification of needs, development and implementation of supports to meet needs, and the monitoring and evaluation of outcomes.

Professional Judgment: Refers to the adherence to high standards, based on research, and informed practice, that are established by professional organizations (Katz, 1984).

Services and Service Delivery: Refers to assistance provided by professionals. They also refer to the manner in which assistance/interventions are organized school-wide or district-wide.

Special Education: Special education is especially designed instruction, at no cost to parents or guardians, to meet the unique needs of a child with a disability.' [20 U.S.C. Chapter 33 & 1401 (a)(16)] . Special education is not considered an intervention, nor is special education a place or teacher. It should be noted that many supports, services, and interventions to address students' needs are provided outside of a special education system.

Students' Needs: This term is used in the broadest sense in this document. They could include students' needs for increased competence and skills in many domains, including academic, social behavioral, community living, and other areas. They could also include the need for environmental or instructional modifications to promote academic, social and life skills attainment. This term also incorporates the need for educational services that are responsive to individual and cultural diversity.

Supports: Supports are defined broadly to include any assistance, which enables children to increase their competence, and have their needs met. Supports include professional services and collaboration, environmental and instructional modifications, accommodations, interventions, adapted curriculum, physical assistance, social support, behavioral support, friendship facilitation, equipment and materials.

Supports and Levels

(For purposes of assisting the field the following is included to assist IEP teams when interacting with adult facilities and county developmental disability boards.)

In the 1992 AAMR definition of Mental Retardation (Cognitive Disabilities in Wisconsin), levels of supports are used to reflect intensities of supports and services necessary for individuals with CD to become more independent, productive, and integrated into the community. The concept of needed supports reflects the contemporary perspective regarding the expectation for growth and potential of people; focus on personal choice, opportunity and autonomy; and the need for people to be both in and of the community.

The AAMR definition describes support-based framework in which assessment results are directly linked to individualized intervention and services. AAMR (1992) recommends that assessment include an evaluation of the types and intensities of supports that enable the individual to succeed in his or her current educational settings. These supports may vary across a number of dimensions.

Types of Supports described in AAMR (1992) include:

1. Befriending,
2. Financial planning,
3. Employee assistance,
4. Behavior support,
5. In-home living assistance,
6. Community access,
7. Health assistance.

First, supports may be limited to specific adaptive skills areas, type of services, or settings. Second, supports may range from time-limited (short-term interventions) to ongoing, long-term programming. Third, intensities of support may vary across individuals and may change during the person's life cycle. Finally, supports may vary with respect to the number of personnel needed to implement interventions and services. AAMR (1992) descriptions of intensities of support are categorized across the following four levels. The levels of supports are discussion items for the IEP team as they discuss whether the student needs special education and related services. They can be defined as follows:

1. Intermittent: Supports on an "as needed basis." Short-term supports needed during life span transitions (e.g., beginning kindergarten, job loss).
2. Limited: Characterized by consistency over a time-limited basis (toilet training, time-limited employment training, transitional supports).
3. Extensive: characterized by regular involvement (daily) across some environments and not time-limited (e.g., facilitation of participation in classroom activities, long-term home living support).
4. Pervasive: Characterized by constant, high intensity support across environments, and may include potentially life-sustaining measures.

Eligibility Worksheet **Cognitive Disability** Student name: _____
PI 11.36 (1)

DEFINITION

Cognitive Disability means:

Significantly subaverage intellectual functioning that exists concurrently with deficits in adaptive behavior and that adversely affects educational performance.

1. **Intellectual Functioning** ❑ Yes ❑ No

   a. The child has a standard score of two or more standard deviations below the mean.

      Data used to support determination:

OR

   b. The child has a standard score of one and two standard deviations below the mean; and
      The child has been documented as having a cognitive disability in the past; and
      The child's condition is expected to last indefinitely.

      Data used to support determination:

2. **Adaptive Behavior** ❑ Yes ❑ No

   The child has deficits* in adaptive behavior as demonstrated by a standard score or two or more standard deviations below the mean. These areas include: (check all that apply)

   a. Communication (from age 3-21)
   b. Self-care (from age 3-21)
   c. Social skills (from age 3-21)
   d. Home living skills (from age 6-21)
   e. Appropriate use of resources in the community (from age 6-21)
   f. Self-direction (from age 6-21)
   g. Health and Safety (from age 6-21)
   h. Applying academic skills in life (from age 6-21)
   i. Leisure (from age 6-21)
   j. Work (from age 14-21)

   *Deficits are interpreted to mean **two** or more of the age relevant adaptive behavior areas.

   Adaptive behavior areas that were found deficit:

   Data used to support determination:

3. **Academic Functioning** ❑ Yes ❑ No

The child is **age three through five** and has a standard score of two or more standard deviations below the mean in at least two of the following areas:

❑ Yes ❑ No 1. Academic readiness
❑ Yes ❑ No 2. Comprehension of language or communication
❑ Yes ❑ No 3. Motor Skills

Data used to support determination:

The child is **age 6 to 21** and has a standard score of two or more standard deviations below the mean in:

❑ Yes ❑ No 1. General information

Data used to support determination/explanation of results:

And at least two of the following areas:

❑ Yes ❑ No 1. Written language
❑ Yes ❑ No 2. Reading
❑ Yes ❑ No 3. Mathematics

Data used to support determination:

Need for Special Education

Yes	1. Does the student have needs that cannot be met in regular education as structured? *If yes, list the needs below. Use reverse side or attach additional pages if needed.*
No	*If no, there is no need for special education.*
Yes	2. Are there modifications that can be made in the regular education program to allow the student access to general education curriculum and to meet the educational standards that apply to all students? (Consider adaptation of content, methodology and/or delivery of instruction.) If yes, *A. List modifications that do not require special education. Use reverse side of page or attach additional pages if needed.* *B. List modifications that require special education. Use reverse side of page or attach additional pages if needed.*
No	*If no, go to question 3.*
Yes	3. Are there additions or modification that the child needs which are not provided through the general education curriculum? (Consider replacement content, expanded core curriculum, and/or other supports.) *If yes, list below. Use reverse side of page or attach additional pages if needed.*
No	

In order for the IEP team to determine that the student needs special education, the IEP team must answer "yes" to question 1 **AND** list needs under 2B and/or 3.